U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT
ENFORCEMENT AND REMOVAL OPERATIONS
ICE HEALTH SERVICE CORPS

CONTINUOUS QUALITY IMPROVEMENT ACTIVITIES

IHSC Directive: 11-02
ERO Directive Number: 11834.2
Federal Enterprise Architecture Number: 306-112-002b
Effective Date: 25 Mar 2016

By Order of the Acting Assistant Director
Stewart D. Smith, DHSc/s/

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1. PURPOSE: The purpose of this issuance is to set forth the policies and procedures for establishing systematic activities that are organized and implemented for monitoring and improving quality of healthcare services delivery and managing risks.

2. APPLICABILITY: This directive applies to all Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) personnel, including but not limited to, Public Health Service (PHS) officers and civil service employees supporting health care operations in ICE-owned or contracted detention facilities and to IHSC Headquarters (HQ) staff. This directive applies to contract personnel when supporting IHSC in detention facilities and at HQ.

3. AUTHORITIES AND REFERENCES:

3-1. Division of Immigration Health Services (DIHS), Performance Improvement Plan, 2005.

3-2. ICE Health Service Corps (IHSC) Continuous Quality Improvement Activities Guide.

3-3. Medical Quality Management Directive; DHS MD Number 248-01 (October 2, 2009).

3-4. Medical Quality Management Instruction; DHS Instruction Number 248-01-001 (September 10, 2012).

4. POLICY: IHSC, through its Medical Quality Management Unit (MQMU), ensures quality healthcare delivery and accountability through robust continuous quality improvement (QI) activities and risk mitigation strategies.

4-1. Continuous Quality Improvement (CQI) Model. CQI is a systematic and continuous approach to quality management that promotes the need for objective data to identify, analyze, monitor and improve processes. CQI does not seek to blame individuals, but rather to improve processes.

4-2. CQI Evaluation Components. The CQI program staff monitors services and functions that have a direct or indirect influence on the quality of appropriate and necessary care rendered to the designated population, including, but not limited to:

a. Regulatory and licensing compliance (federal and state);

b. Risk management (RM);

c. Internal comprehensive audits;

d. Patient safety;

e. Medical records review;

f. Medical, mental health and dental care; and

g. Local quality improvement oversight.

4-3. IHSC Staff Responsibilities.

a. IHSC Assistant Director (AD). The IHSC AD approves policies and procedures to improve organizational performance and facilitates the safe delivery of quality health care to all detainees.

b. Senior Leadership. Senior Leadership recommends and advises the IHSC AD on appropriate courses of action. Senior leadership is composed of: Deputy Assistant Director-Administration (DAD-A), Deputy Assistant Director-Clinical Services (DAD-CS), Chief of Staff, Medical Director, and the Associate Medical Director (AMD).

c. Chief, MQMU. The Chief is responsible for overseeing the activities of a robust agency-wide CQI program and ensuring established processes complies with policy, procedures, standards, State/Federal regulations and any other applicable guidance based on:

(1) ongoing identification of opportunities for change;

(2) monitoring trends;

(3) developing and achieving measurable improvements in processes and outcomes; and

(4) decreasing litigation risks.

He or she consults with and provides updates to senior leadership regarding IHSC-wide CQI/RM Program activities.

d. Continuous Quality Improvement (CQI) Risk Management Program Manager (RMPM). The RMPM provides guidance to IHSC staff regarding the RM program, and collaborates with the Compliance Administrator (for CQI), QI Coordinators and Compliance Investigators to identify, assess and proactively reduce litigation risks. The CQI-RMPM oversees the RM team members.

e. Continuous Quality Improvement-Risk Management (CQI-RM)-Program Coordinator. The CQI/RM Coordinator supports the RM team and guides and consults with staff regarding the Root Cause Analysis (RCA), incident reports, or any other risk management-related activities.

f. National Continuous Quality Improvement (CQI) Coordinator. The National CQI Coordinator (located at IHSC HQ) supports the CQI program and consults on administrative and/or clinical issues to provide guidance, educate and clarify standards of care, practice and policy.

g. Compliance Administrator. The Compliance Administrator assigned to the CQI Program administers the QI Program, utilizing a variety of activities, tools and methods to improve quality, assess, and proactively reduce risk, and ensure safe practices are being utilized..

g. National Continuous Quality Improvement Committee. The National Quality Improvement Committee, comprised of designated IHSC Consultants and Chiefs, provides a multidisciplinary collaborative approach to improving the quality of patient care and safety. The Committee reviews and endorses the CQI annual report and annual plan.

h. Health Service Administrators (HSAs) and Clinical Directors (CDs). The HSAs and CDs oversee and integrate QI, RM and patient safety activities in their local facilities. They appoint a local QI Coordinator to perform these activities.

i. Local Quality Improvement Committees. Each Local QI Committee is a multidisciplinary team assigned by the local governing body for the purpose of improving performance and promoting patient safety.

j. Local Quality Improvement Coordinators. The Local QI Coordinator, in collaboration with the HSA, is responsible for designating the members of the Committee. The Local QI Coordinator serves as a liaison between the local QI Committee and the National CQI Coordinator and coordinates the local quality improvement activities and ensures that data is reported to IHSC HQ as requested. The local QI coordinator ensures that quarterly audit results are submitted to the National CQI Coordinator; ensures that process and/or outcome studies are completed based on locally identified problems; and ensures that a Healthcare Failure Mode and Effect Analysis (HFMEA) is completed locally on an annual basis

k. IHSC Staff. All staff are expected to actively participate in creating a safe environment by meeting organizational and professional standards, following identified best/safe practices, and proactively mitigating unsafe conditions or situations.

4-3. Scope of Performance Measurement Activities. Performance indicators measure the performance and stability of processes used in delivering patient care services and the associated outcomes. Measures are developed at various levels throughout the organization and focus on correctional community standards, quality of patient care delivery, the efficiency and effectiveness of the processes used to provide that care, and those processes that are high risk, high volume and tend to be problem prone and/or offer opportunities for improvement.

Performance measures are related to Patient-Focused Functions and Organizational Functions.

a. Patient-Focused Functions. Patient-focused functions relate to patients' rights, provision of patient care, and treatment and services provided:

(1) Access to Care;

(2) Quality of Care;

(3) Grievances;

(4) Language Access;

(5) Chronic Care;

(6) Pregnancy;

(7) Continuity of Care;

(8) Sick Call;

(9) Medication Management (Medication Errors and Pharmacy Monitoring: Asthma, Coumadin, Diabetes, and Psychotropics); and

(10) Reasonable Accommodations.

b. Organizational Functions. Organizational functions relate to improving organizational performance and management of environment of care. They include:

(1) Continuous Quality Improvement Program Annual Report;

(2) Process Studies (focuses on procedural or policy oriented issues);

(3) Outcome Studies (focuses on a desired outcome);

(4) Healthcare Failure Mode and Effect Analysis (HFMEA);

(5) Staff Satisfaction Surveys;

(6) Incident Reports; and

(7) Root Cause Analysis (RCA) and Corrective Action Plans (CAP).

c. **Data Collection**. Data is collected from a variety of sources to assess organizational performance and determine if quality care is being provided. Sources include, but are not limited to:

(1) Patient encounters;

(2) Patient incidents;

(3) Risk management program activities;

(4) Surveys; and

(5) Detainee health records.

d. **Analysis**. Analysis is conducted using statistically valid, aggregate data to determine causes of process and outcome variation.

e. **Improvement**. Improvements are identified through data collection and analysis, and are addressed with the use of Plan-Do-Check-

Act (PDCA) methodology to make process or organizational improvements.

f. **Local Quarterly Reporting**. Local QI reports are submitted quarterly to the National QI Program Manager. Reports should consist of the source of information, and analysis and improvement plan.

g. **Local Annual Reporting.** The local QI Coordinator, in collaboration with the HSA, writes an annual QI Program Review, due October 31 of each year. The Program Review consists of:

(1) An introduction;

(2) A summary of objectives for the year:

(3) The members of the QI team;

(4) Staff training completed in QI;

(5) QI Studies and Healthcare Failure Mode and Effects Analysis (HFMEA); and

(6) Planned QI initiatives for the coming year.

h. **National CQI and RM Annual Reporting.** The Compliance Administrator for CQI, in collaboration with the CQI-RM Program Manager will submit an annual report to the MQM Unit Chief by October 31st of each year. Reports should consist of:

(1) Overview of the Program;

(2) Objectives for the year;

(3) Fiscal Year (FY) accomplishments and next year's goals;

(4) New initiatives;

(5) Resource requirements (to include training);

(6) Risks/challenges (including impact and mitigating strategies).

5. PROCEDURES: See the IHSC *Quality Improvement and Risk Management Programs Guide* and *Root Cause Analysis Guide* located at: All Guides.

6. HISTORICAL NOTES: This directive replaces the DIHS Performance Improvement Plan, 2005 and Chapter 5 of the legacy DIHS Policies and Procedures Manual.

7. DEFINITIONS:

7-1. **Quality Improvement.** Quality improvement is a prospective and retrospective review aimed at improvement: measuring where you are, and figuring out ways to make things better. It specifically attempts to avoid attributing blame, and to create systems to prevent errors from happening.

7-2. **Process Study**. A process study examines the effectiveness of the health care delivery process by (1) identifying a facility problem; (2) conducting a baseline study; (3) developing and implementing a clinical corrective action plan; and (4) restudying the problem to assess the effectiveness of the corrective action plan.

7-3. **Outcome Study.** An outcome study examines whether expected outcomes of patient care were achieved by (1) identifying a patient clinical problem; (2) conducting a baseline study; (3) developing and implementing a clinical corrective action plan; and (4) restudying the problem to assess the effectiveness of the corrective action plan.

7-4. **Healthcare Failure Mode and Effect Analysis (HFMEA).** The HFMEA is a systematic prospective risk reduction assessment methodology that identifies and improves steps in a process before they occur, thereby reasonably ensuring a safe and clinically desirable outcome. HFMEA is a bottom-up approach to analyzing processes, system designs and performance.

7-5. **Plan-Do-Check-Action (PDCA).** PDCA is a four step formalized methodology used to guide system/process improvements.

8. APPLICABLE STANDARDS:

8-1. **Performance Based National Detention Standards (PBNDS):** 4.3 Medical Care, Section BB, *Administration of the Medical Department.*

8-2. **ICE Family Residential Standards:** 4.3 Medical Care, V. Expected Practices; 25. *Administration of the Medical Department.*

8-3. **American Correctional Association (ACA):** 4-441, *Internal Review and Quality Assurance*; 1-HC-4A-03, *Internal Review and Quality Assurance*; 4-ALDF-7D-01 and 4-ALDF-7D-02, *Quality Improvement Practices.*

8-4. **National Commission on Correctional Health Care (NCCHC): Standards for Jails, 2014.**

J-A-06, *Continuous Quality Improvement Program.*

9. PRIVACY AND RECORDKEEPING. IHSC stores, retrieves, accesses, retains, and disposes of these records in accordance with the Privacy Act and as provided in the Alien Medical Records System of Records Notice, 80 Fed. Reg. 239 (January 5, 2015). The records in the electronic health record (eHR)/eClinicalWorks (eCW) are destroyed ten (10) years from the date the detainee leaves ICE custody. Retention periods for records of minors may differ. Paper records are scanned into eHR and are destroyed after upload is complete.

Protection of Medical Records and Sensitive Personally Identifiable Information (PII).

9-1. Medical records, whether electronic or paper, may only be disclosed to or accessed by those officers and employees of the agency which maintain the record who have a need for the record in the performance of their duties. Paper records must be secured at all times within a locked cabinet or room when not under the direct control of an officer or employee of the agency with a need for the record in the performance of their duties.

9-2. Staff is trained at orientation and annually on the protection of patient medical information and Sensitive PII.

9-3. Staff references the Department of Homeland Security *Handbook for Safeguarding Sensitive Personally Identifiable Information* (March 2012) at:

(b)(7)(E) [redacted]

when additional information is needed concerning safeguarding Sensitive PII.

10. NO PRIVATE RIGHT STATEMENT. This directive is an internal policy statement of IHSC. It is not intended to, and does not create any rights, privileges, or benefits, substantive or procedural, enforceable against the United States; its departments, agencies, or other entities; its officers or employees; or any other person.